

FORM 16-10



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Superintendent of Education

DEPARTMENT OF EDUCATION OFFICE OF THE ADMINISTRATOR STUDENT SUPPORT SERVICES DIVISION

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CHRISTOPHER J. ANDERSON
Administrator, Student Support Services

SCHOOL BASED BEHAVIORAL HEALTH REFUSAL OF SERVICES FORM

Name of Student: _____ Date of Birth: _____

I, _____ have been notified that my child was recommended to participate in the Guam Department of Education's School Based Behavioral Health Program (BHS). I understand that the **benefits of the BHS program may include improvements in my child's:** 1) psychological health; 2) physical health; and 3) overall well-being. I understand that the **risks of the BHS program may include:** 1) Desired outcomes may not be achieved and 2) Behaviors/Symptoms may get worse during the course of services.

I willingly have decided for my child to (please check all applicable boxes):

- Refuse Service and Support Plan
- Refuse Intake Assessment
- Refuse Counseling Services: Individual, Group, and Family
- Refuse Emergency Crisis Services
- Refuse Substance use Services
- Refuse Other (Please Specify):

Potential consequences of refusal (i.e., worsening of mental health condition, etc.) explained to the individual and parent(s) or legal guardian(s):

Parent(s) or Legal Guardian(s): Print Name _____ Signature _____ Date _____

Clinician: _____ Print Name _____ Signature _____ Date _____